Arkansas Department of Workforce Services

SHARED WORK UNEMPLOYMENT COMPENSATION

Information and Application For Employers

ARKANSAS DEPARTMENT OF WORKFORCE SERVICES

Shared Work Information

This booklet contains information and instructions for completion of the Employer Work Sharing Plan Application and the weekly certification, which you give to your employees. Please read the booklet carefully and retain it in your files for future reference. If you have questions, please contact the Department of Workforce Services Local Office in your area.

General Information:

The Shared Work Unemployment Compensation Program provides an alternative for employers faced with a reduction in work force. It allows an employer to divide available work or hours of work among a specific group(s) of employees in lieu of a layoff, and it allows the employees to receive a portion of their unemployment benefits while working reduced hours.

To qualify for benefits under the Shared Work (SW) Program, employees must be regularly employed by an employer whose plan to stabilize the work force has been approved by the Administrator of the Department of Workforce Services or his duly authorized representative. During the period for which benefits are payable, the following conditions must be met:

1. The employee's normal weekly hours of work are reduced at least 10%.
2. The employee must be monetarily eligible for regular unemployment insurance benefits and must not have exhausted the entitlement to regular UI benefits.
3. The employee must file a claim and meet the eligibility requirements for regular Arkansas Benefits. The employee need not:
   a. Be available for work other than with the Shared Work Employer.
   b. Conduct an active search for work, or
   c. Apply for or accept work other than from the Shared Work employer.
4. The employee must be able and available for the normal hours of work of the Shared Work Employer:

   Example: The employee's hours of work are reduced twenty (20) percent. The employer schedules a four (4) day work week, eight (8) hours a day, Monday through Thursday. An employee requests and is granted permission to be off Tuesday. If the Shared Work employer schedules the claimant / employee to work eight (8) hours on Friday, the claimant / employee must be able and available to work the scheduled hours.

Employees included in an approved plan may not receive Shared Work benefits for any week for which he receive regular benefits, nor may an employee participate concurrently in two or more Shared Work Plans.

Employees involved in an employer's approved SW program, if otherwise eligible, will receive that percentage of their weekly unemployment insurance benefit amount which equals the percentage of reduction in normal hours for that week due to Shared Work. If additional hours are worked during the week in the employment of another employer(s), the combined hours of work for both employers will be used to determine the percentage of reduction of their weekly unemployment insurance benefit amount. However, if the combined hours are equal to or greater than 90%, of the normal weekly hours of work with the Shared Work employer, the claimant shall not be entitled to SW benefits.

NOTE: All claimants/employees must serve or have served a one-week waiting period. The waiting period is the first week claimed in which the claimant/employee is otherwise eligible for benefits after establishing a claim. No benefits are payable for the waiting week.

A Shared Work Plan becomes effective on the date the plan is approved or on a date mutually agreed upon by the employer and the Administrator of the Department of Workforce Services, but no earlier than the date of approval of the plan by the Administrator. It shall expire at the end of the 12th full calendar month after the effective date or on the date specified whichever date is earlier. If a plan is revoked by the Administrator, it shall terminate on the date specified in the Administrator's written order of revocation.

NOTE: An employer's plan may be revoked before the expiration date if the plan is not carried out according to its terms and intent. Employee's fringe benefits must be continued without reduction. A Shared Work Plan shall not be approved or shall be revoked if fringe benefits are reduced.

Claimants/Employees can receive up to 26 weeks of Shared Work Benefits.

Shared Work Unemployment Compensation

Definitions

Shared Work Plan

An employer's plan under which there is a reduction in the number of hours worked by employees rather than temporary layoffs.

Normal Weekly Hours of Work

The normal hours of work for full-time and permanent part-time employees in the affected group when their employing unit is operating on its normal, full-time basis, not to exceed forty hours and not including overtime.

Affected Groups(s)

At least two or more employees designated by an employer to participate in a Shared Work Plan.

Hours Worked

All hours worked by a Shared Work claimant/ employee during the week.

Shared Work Benefits

The unemployment compensation benefits payable to employees in an affected group under an approved Shard Work Compensation plan as distinguished from the benefits otherwise payable under the Arkansas Employment Security Law.

Subgroup

A group of employees constituting at least ten percent of the employees in an affected group.

Section 11-10-507(5) of the Arkansas Employment Security Law

(A) To qualify for benefits for any benefit year, an individual has during his base period been paid wages in at least two quarters of his base period for insured work; and such total wages paid during his base period equal not less than twenty-seven (27) times his weekly benefit amount.

(B) To requalify for benefits for all benefits years, no individual may requalify on a succeeding benefit year claim unless he had been paid wages for insured work equal to not less than twenty-seven (27) times his weekly benefit amount and has wages paid for insured work in at least two (2) calendar quarters of his base period, and subsequent to filing the claim which established this previous benefit year, he has had insured work and was paid wages for such work equal to three (3) times his weekly benefit amount.

Base Period

The first four (4) of the last five (5) completed calendar quarters immediately preceding the first day of the quarter in which the claim is filed.

Employer Charges

Any employer who elects to participate in the Shared Work Program must have a positive reserve account. Thus, his account would be charged in the usual manner. A reimbursable employer will be required to reimburse the Unemployment Insurance Fund for the cost of benefits paid based on wages paid by him. Please contact the Employer Charge Unit at (501)682-3236, if you have any further questions regarding employer charges.

Advantages:

- Production and quality levels are maintained.
- Rapid recovery to full capacity is possible because of the retention of an experienced work force.
- When the economic climate improves, administrative and training costs of hiring new employees are minimized.
- Affirmative action gains are protected.
- Employee morale remains high.
- Employees retain their skills and advancement opportunities.
- Consumer's spending patterns remain more stable.
- Public assistance expenditures may be lessened.

Disadvantages:

- Employees who are able to locate full employment elsewhere may be lost.
- Work scheduling may be more difficult.
- Senior employees suffer a reduction in hours and income.

Shared Work Unemployment Compensation

How To Apply for a Shared Work Plan

Interested employers must submit an affected Group Pre check List attached on page 6 for each affected group. The Department of Workforce Services Local Office Manager designee shall pre check the list, and return it to the Employer before application on pages 7-9 is submitted.

NOTE: All employees listed must meet the requirements of Section 11-10-507 of the Arkansas Employment Security Law. Otherwise, the plan shall not be approved.

If all employees on the list do not meet the requirements of Section 11-10-507 you may elect to divide the plan into groups.

The employer must certify that:

1. The aggregate reduction in work hours is in lieu of temporary layoffs which would have affected at least ten (10) percent of the employees in the affected group or groups to which the plan applies and which would have resulted in an equivalent reduction in work hours.
2. Each employee in the affected group would be eligible for normal unemployment compensation under Section 11-10-507 of the Arkansas Employment Security Law.
3. In the case of employees represented by an exclusive bargaining representative, the plan is approved in writing by the collective bargaining agent. In the event that the certification of an exclusive bargaining representative has been appealed, such bargaining representative shall be considered to be the exclusive bargaining representative for work sharing plan purposes. In the absence of any such bargaining representative, the plan must contain a certification by the employer that he has made the proposed plan or a summary thereof, available to each employee in the affected group for inspection.

The Employer's Plan must meet the following criteria:

(1) The plan applies to and identifies the specified affected group.

(2) The employees in the affected group or groups are identified by name, social security number, normal weekly hours of work, percentage of reduction and whether or not the affected employees are under a collective bargaining agreement or if such certification of a collective bargaining agent is on appeal.

(3) The normal weekly hours of work for employees in the affected group or groups are reduced by not less than ten (10) percent and not more than forty (40) percent.

(4) Health benefits and retirement benefits under defined benefit pension plans (as defined in Section 3(35) of the Employee Retirement Income Security Act of 1974), and other fringe benefits will continue to be provided to employees in the affected group or groups as though their work weeks had not been reduced.

(5) During the previous four (4) months the work force in the affected group has not been reduced by temporary layoffs of more than ten (10) percent of the workers.

(6) On the most recent computation date preceding the date of submittal of the Shared Work Plan for approval, the total of all contributions paid on the employing unit's own behalf and credited to his account for all previous periods equaled or exceeded the regular benefits charged to his account for all such previous periods.

(7) The plan applies to at least ten (10) percent of the employees in the affected group. If the plan applies to all employees in the affected group, the plan provides equal treatment to all employees of the group. If the affected group is divided into subgroups, the plan provides equal treatment to all employees within each subgroup.

(8) The plan will not serve as a subsidy of seasonal employment during the off season, nor as a subsidy of temporary part-time or intermittent employment.

(9) The employer agrees to furnish reports relating to the proper conduct of the plan and agrees to allow the Administrator or his authorized representatives access to all records necessary to verify the plan prior to approval and, after approval, to monitor and evaluate application of the plan.

Shared Work Unemployment Compensation

Instructions For Completing the Affected Group Pre check List

Items are self-explanatory. Complete all information for each employee in the affected group either alphabetically by last name or numerically by social security number. The form may be duplicated if necessary. Please insure that the form contains the information requested, is readable for keypunching, and is printed in the format shown.

Instructions for submitting a Shared Work Plan Application for Approval

Complete the application form and the affected employee listing. To insure employee's forms are processed for Shared Work benefits for each week following a reduction in hours, submission of these items at least 30 days in advance of the effective date is advisable. You will be notified by mail of the approval or disapproval of your plan. Please contact the Department of Workforce Services Local Office if you have questions.

Upon completion of the form(s) you should submit it to the Local Department of Workforce Services office nearest your place of business.

Explanation of Items on the application forms. Complete Items 1-13, sign, and date the certification statement.

Section A: Employer Information

Item - 1 Self-explanatory.

Item - 2 Complete only if the name of the company/subsidiary is different than listed in Item 1.

Item - 3 Self-explanatory.

Item - 4 Enter the complete mailing address.

Item - 5 Enter the date you wish your Shared Work Plan to begin. Shared Work Plans begin on a Sunday and may begin no earlier than the Sunday immediately following the date the plan was approved by the Department of Workforce Services. Your plan may begin on any future Sunday. Enter the month, date and year.

Item - 6 Enter a Saturday date (Month, date, and year). If approved, your plan will expire at the end of the 12th full calendar month after the effective date of the plan or on the date specified in the plan if such date is earlier; provided, that the plan is not previously revoked by the Administrator.

Item - 7 Enter the number of employees to be included in the plan as listed on the Shared Work Plan Affected Employees Listing.

Item - 8 Self-explanatory.

Item - 9 Self-explanatory.

Item - 10 Enter the percentage that you expect to reduce the normal weekly hours of work of the affected employees.

Item - 11 Specify the type of business you operate (e.g. manufacturing boats, manufacturing tractor parts, engineering-civil, engineering- structural, etc.).

Item - 12 Complete this Item if any employee included in the plan is represented by a collective bargaining agent. Indicate the group(s) that are affected by your plan (e.g., clerical, assembly, serving, transportation, sales, etc.). If the affected group is covered by a collective bargaining agreement, enter the union name in the appropriate space. Enter the total number of employees in each affected group, if appropriate, and the number of employees sharing work.

NOTE: The application for the Shared Work Program must be signed by the collective bargaining representative(s), if Item 12 is completed.

(Continued on Reverse Side)

Shared Work Unemployment Compensation

Section B Statements are Self-Explanatory. If there is more than one owner, prepare an attachment which provides the same signature information in a similar format.

Section C For ESD Use Only.

Instructions for Completion of the SW-Affected Employees Listing

Items are self-explanatory. Complete all information for each affected employee either alphabetically by last name or numerically by Social Security Number. The form may be duplicated if necessary. Please ensure that the form contains the information requested, is readable for keypunching and is printed in the format shown. (This form must accompany the Shared Work Plan Application.)

Instructions For Completion of Weekly Certification For Shared Work Unemployment Compensation (Form SWC-2)

Complete a Shared Work Weekly Certification only for your employees who are included in your approved Shared Work Plan.

Issue a SWC-2 for the seven consecutive day period that corresponds to the Saturday week-ending date. If the company's payroll period is other than weekly, the employer must report the percent of reduced hours on a calendar week beginning Sunday and ending Saturday.

Section A - shall be completed, signed and dated by the Employer.
(Items 1 through 7, self-explanatory.)

Section B - shall be completed, signed and dated by the claimant/employee.
(Items 1 through 3, self-explanatory.)

The Weekly Certification Claims Forms must be returned to the Department of Workforce Services Holding Of the Employer's Shared Work Plan no later than 7 days after the week-ending date (Saturday's date) on the form.

*Failure to submit the SWC-2 Forms as directed could result in a delay or denial of benefits.

An example of a Weekly Certification Form is on page ten (10). Please read and follow instructions as outlined on the form. The Shared Work Program will function more effectively if both you and your employees carefully review the explanations and follow the instructions.

**Complete a separate "Shared Work Plan Application" for each subgroup, and annotate "Subgroup" on the application.

DWS-ARK-SWC-1a (Rev. 10-01) ARKANSAS DEPARTMENT OF WORKFORCE SERVICES

Shared Work Plan - Affected Group Pre check List

Please Type or Print in Black Ink		For DWS Use Only	
Employer (Company) Name		Section 11-10-507 Requirements Met	
Employee Name (Last Name, First Name)	Employee Social Security Number	Yes	No
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			
21.			
22.			
23.			

DWS-ARK-SWC-1b (Rev. 10-01) ARKANSAS DEPARTMENT OF WORKFORCE SERVICES

Shared Work Plan Application

For DWS Use Only
Plan No.

Section A. Employer Information

Please Type or Print in Black Ink

1. Enter Company Name as shown on most recent Quarterly Report | U.I. Employer Acct. No.

2. Business Name (Enter "Same" if same as #1) | 3. Business Phone No.

4. Mailing Address (No., Street or P.O. Box, City, State , ZIP)

5. Plan Start Date: On what date (must be a Sunday date) do you want this plan to become effective? _____

6. Plan End Date: On what date (must be a Saturday date) do you want this plan to end? _____

7. Number of employees to be covered by the plan as listed on the attached Affected Employee Listing. _____

8. The main work location of employees listed on this plan is:

(Street Address) _____
(Complete only if different than Item 4)

(City) _____ (County) _____ (Zip) _____ (Phone No.) _____

9. Since the work hours of employees listed on this application are reduced to less than their normal weekly hours will their fringe benefits be affected? ❑ Yes ❑ No If Yes, how? (Please be specific) ____

_____

_____

10. Expected weekly reduction in hours _____ %

11. Specific type of business _____

12. List collective bargaining representative(s) for any employee(s) covered by this plan, even if such certification of the collective bargaining agent is on appeal:

Affected Group	Bargaining Agent	No. of Employees in Group
A.		
B.		
C.		

I approve of this Shared Work Plan:

Signature, Official A.	Date	Union Name	Local No.
Signature, Official B.	Date	Union Name	Local No.
Signature, Official C.	Date	Union Name	Local No.

(Continue on Reverse side)

Section B. Employer Certification

13. Employer Certification:
    a. Each employee in the affected group covered by this plan is eligible for regular unemployment compensation under Section 11-10-507 of the Arkansas Employment Security Law.
    b. The aggregate reduction in work hours is in lieu of temporary layoffs which would have affected at least ten (10) percent of employees in the affected group or groups to which the plan applies.
    c. The hours of work for each affected employee will be reduced by not less than ten (10) percent and not more than forty (40) percent.
    d. During the previous four (4) months the workforce of the affected group has not been reduced by temporary layoffs of more than ten (10) percent of the workers.
    e. I certify that I have made the proposed plan or a summary thereof available, to each affected employee not representative by a collective bargaining representative for inspection.
    f. I agree to furnish reports relating to proper conduct of the plan and agree to allow the Administrator of his authorized representative access to all records necessary to verify the plan prior to approval and after approval, to monitor and evaluate application of the plan.
    g. I understand that the plan may be revoked, if the hours of work are "increased" or "decreased" substantially beyond the level in the plan.
    h. I am aware of the potential affects on my Unemployment Insurance Account (experience rated or reimbursable) if Shared Work benefits are paid to my employees.
    i. I also understand that any substantial change in the plan must be approved by the Administrator of the Department of Workforce Services.
    j. I understand that the fringe benefits of the affected employees shall not change as long as the Shared Work Plan is in affect.
    k. I have read and understand the Shared Work Information and Application Instructions.

Owner, Partner of Corporate Officer (Type or Print)	Contact Person	Telephone Number
Owner, Partner of Corporate Officer Signature	Title	Date Submitted

Section C: Plan Disposition

For DWS Use Only - Do Not Complete Below This Line

14. Plan Disposition: I recommend ❑ Approval ❑ Disapproval

Reasons: _____

_____

_____

Department of Workforce Services Representative	Date

15. Determination: The plan is ❑ Approved ❑ Disapproved for reasons cited in Item 14.

Approved By:	Title	Date

DWS-ARK-SWC-1c (Rev. 10-01) ARKANSAS DEPARTMENT OF WORKFORCE SERVICES

Shared Work Plan - Affected Employee Listing

Please Type or Print in Black Ink		For DWS Use Only
Employer (Company) Name	U.I. Employer Acct. No.	Plan No.

Employee Name (Last Name, Initials)	Employee Social Security No.	Normal Weekly Hours of Work (Max. of 40 Hrs)	Percentage of Reduction	Under Collective Bargaining Agreement	
				Yes	No
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
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21.					
22.					
23.					
24.					

DWS-ARK-SWC-2 (Rev. 10-01) ARKANSAS DEPARTMENT OF WORKFORCE SERVICES

Weekly Certification For Shared Work Unemployment Compensation

Section A: Employer Statement

Name of Employer	Employer Plan No.	Week Ending (Saturday Date)

1. Normal weekly hrs. _____ Number hrs. work week reduced _____ Number hrs. worked _____
2. Was the reduction in hours worked by this employee the same as was agreed upon in the Shared Work Plan? ❑ Yes ❑ No If "No," what percentage of reduction _____ %
3. Was employee absent from work for reasons other than Shared Work? ❑ Yes ❑ No
   If "Yes," was absence with your approval? _____ If "No," give date(s) and reason: _____
   _____
4. Did employee refuse any work you made available to him during the above? ❑ Yes ❑ No
   (If "Yes," please attach a note of explanation with this claim form.)
5. Other pay to be received for this week: Bonus pay, Holiday pay, Sick pay.
   (Circle that which applies) Amount $ _____
6. Were you closed for Vacation or Holiday purposes during any part of the above week? ❑ Yes ❑ No

Employer's Certification: I certify that the above information concerning the status of this company and the status/hours of this employee for the purpose of participating in the Shared Work Program is true and correct to the best of my knowledge.

Employer's Signature	Title	Date

Section B: Employee / Claimant Statement

Employer Claimant Name	Social Security Number	Week Ending (Saturday Date)

The following questions are for the seven-day period that ends on the Saturday date above. Answer each question.

1. During the above week, were you able and available for all the hours of work made available to you by your Shared Work Employer? ❑ Yes ❑ No
   (If "No," please attach a note of explanation with this claim form.)
   a. Total hours worked for your Shared Work Employer _____
   b. Gross earnings for the above week from your Shared Work Employer: $ _____
2. Did you work for anyone other than your Shared Work Employer on any day in the week covered by this claim? (This includes, but is not limited to, self-employment and National Guard or Reserve duty.) ❑ Yes ❑ No If "Yes," provide the following information:
   Employer Name (or Self-employed) and Address: _____
   Number of hours worked: _____ Gross Amount Earned: $ _____
3. Will you receive or have you received any pension, annuity or retirement pay including Social Security? ❑ Yes ❑ No
   If "Yes," Type: _____ Amount Received: $ _____

Employee/Claimant Certification: I claim Shared Work Benefits under the Arkansas Employment Security Law. I certify that the above statements are true and complete, that I was partially unemployed, able to work, available for work with my shared work employer and that my loss of hours in work was due to no fault of mine. I have not claimed unemployment benefits for this period under any other State or Federal system. I realize the Law prescribes penalties for false statements.

Signature	Date	Address (Complete only if changed)

For DWS Use Only	DWS Representative	Date Processed

(Instructions for completing this Form appear on Reverse Side)

Instructions To Employer - Section A

Explanation: The purpose of this Form is to confirm the status of employees which you have listed in your Shared Work Plan during a week for which he is claiming Shared Work benefits.

Procedure: Complete Section A, "Employer Statement." Be sure to show the Saturday date for the week the employee / claimant wishes to claim in the space provided at the top of the Form. Return the Form to your employee /claimant who will complete Section B and return it to the Department of Workforce Services, for processing.

If a worker's hours are reduced for any reason other than lack of work (illness, vacation, personal reason, etc.), include an explanation as part of your statement. If the employee completes Section B and wishes to claim the week, even though you do not agree that this person should be paid for the week, attach a statement setting forth your reason(s) for believing this person should not receive benefits for this week.

NOTE: Complete the information in Section A only for the seven consecutive-day period that corresponds to the above Saturday week ending date. If your payroll period is other than weekly, you must report the percentage of reduced hours on a calendar week beginning Sunday and ending Saturday.

Instructions To Employee / Claimant - Section B

Explanation: This Form is used to claim Shared Work benefits during a week in which your normal work hours of work have been reduced under an approved Shared Work Plan agreed to by your employer.

Procedure: Complete Section B, "Employee / Claimant Statement." Use a calendar week (Sunday through Saturday) for the week you claim (a calendar week begins Sunday and ends at midnight Saturday). Be sure to show the Saturday date for the Week you wish to claim in the space designated "Week Ending (Saturday Date)." You must wait until after the calendar week ends before you complete and mail a claim for that week, for example, you must wait until the 8th to claim a week that ends the 7th. After you complete the Form, return it to your local Department of Workforce Services, within seven (7) days of the weekending date shown on the Form.

Important!

Review the completed Form to be sure that it is correct. Any errors or omissions may cause a delay in payment of benefits!

Any time there is a question about your eligibility for benefits, you will be asked to give a statement regarding the fact. If benefits are denied, you will receive a notice which explains the reason. You have a right to appeal this notice.

Shared Work Unemployment Compensation

Shared Work Responsibilities

After your plan has been approved, "THE PACKAGE," which includes an information sheet, Initial Claims Forms and Weekly Certifications, will be mailed to you for distribution to the affected employees. Each employee must complete an Arkansas Initial Claim for unemployment insurance form, which must be completed and submitted by each affected employee to the Department of Workforce Services Local Office that is handling your Shared Work Plan. Every week during the time the plan is in effect, to claim benefits each affected employee will be responsible for completing a Weekly Certification Form; this Form constitutes their claim for Shared Work benefits.

Modification of an Approved Plan

An operational Shared Work Plan may be modified by the employer with the acquiescence of the employee representative or collective bargaining agent if the modification must be reported promptly to the Administrator. If the hours of work are increased or decreased substantially beyond the level in the original plan, or any other conditions are changed substantially, the Administrator shall approve or disapprove such modification, without changing the expiration date of the original plan. If the substantial modifications do not meet the requirements for approval, the Administrator shall disallow that portion of the plan in writing.

NOTE: To modify an approved plan an employer shall submit written notification to the Administrator of Department of Workforce Services. The request must be certified by the employee representative(s) or collective bargaining agent, if appropriate.

Addition to an Approved Plan

To add an employee to an affected group of an existing Shared Work Plan, the employer must submit written notification to the Administrator of the Department of Workforce Services.

The written notification must include the Shared Work Plan number, employee name, social security number, percentage of reduction and a certification that the employee meets the requirements of Section 11-10-507 of the Employment Security Law.